REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Rt Hon Michael Fallon MP, Secretary of State for Defence**
1	**CORONER** I am Mr D M Salter, HM Senior Coroner for Oxfordshire.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 14 May 2013 I opened Inquests into the deaths of Corporal William Savage, Fusilier Samuel Flint and Private Robert Hetherington who sadly died in Helmand, Afghanistan on 30 April 2013. I concluded the Inquest into their deaths on 3rd December 2014 at Oxford Coroners Court. I gave a conclusion in each case of 'Unlawfully Killed Whilst on Active Service' and, on the Record of Inquest, I made the following finding: *William Savage, Samuel Flint and Robert Hetherington were travelling in the back of a Mastiff Armoured Patrol Vehicle at approximately 1115 hours on 30 April 2013 on Route 611, 6 kilometres north of Lashkar Gah Durai, when it was subjected to a very large strike from an Improvised Explosive Device resulting in their deaths. The IED was placed in a tunnel under the road and triggered by a command wire.* The medical cause of death in each case was blast injuries caused by an explosion. The Inquest heard oral evidence from 14 witnesses. This was from soldiers (including other vehicle occupants) Commanders and subject matter experts from the MOD. There was also evidence from an independent expert who I instructed in the field of armoured fighting vehicle design, specialising in armoured vehicle survivability. The families had concerns about the Mastiff Vehicle and the protection it provided. In particular, there was a question about whether the occupants were made more vulnerable to injury because of damage caused in a previous IED strike on the same vehicle in 2009. In the event, I found there was no significant evidence that the vehicle did not provide the expected level of protection or that the occupants were more vulnerable to the injuries sustained because of the 2009 IED damage. Instead, it appeared to be a case of 'blast overmatch' and that the three soldiers who were killed were seated at the rear of the vehicle nearest the site of the explosion. The other main issue, and the one which is the subject of this report, is the concern on the part of the families that the device could have been detected beforehand. I will address this issue below. I have not provided you with a copy of the Inquest file as a full copy and other documents (some marked as secret) are held by the Defence Inquests Unit. This letter has been copied to the DIU.

4	**CIRCUMSTANCES OF THE DEATH** More specifically, in relation to intelligence, it was known that a surveillance capability (PISTOL) had recorded activity known as a 'hit' at the location in the days preceding the IED strike on 27, 28, 29 April and earlier in the morning of 30 April itself. These hits indicate activities which could include digging activity. On receipt of the hits, relevant personnel at the Patrol Base at Lashkar Gah Durai used other surveillance capabilities to look at the area of interest but nothing suspicious was observed. The hits that were received were frequent and continuous but the assessed threat that was recorded and made available to others (including those organising and conducting the patrol on 30 April) did not convey the fact that the hits were frequent and continuous and lasting over a period of 3/4 days. If the true nature of the hits/ threat had been recorded and shared, the evidence at Inquest was that further actions and possibly a high risk search could have been considered at the location. There was therefore in my view a missed opportunity to carry out more informed consideration, although it is a matter of speculation as to whether in fact any such actions or a high risk search would have been authorised and would have discovered the tunnel/ device. The Battle Captain and Intelligence Analyst who initially received and assessed the possible threat indicated by the PISTOL hits considered tunnelling as a possible explanation but concluded that it was more likely to be due to faulty readings. The decision was also influenced, perhaps understandably, by the fact tunnelling was not a known tactic of the Insurgents. The location of the IED blast on Route 611 was 'cleared' by a US route clearing unit on 29 April as a matter of routine but they did not have the information about frequent and continuous PISTOL hits at the location and carried out a normal 'hasty' clearance by driving along the road, looking for ground signs and utilising the specialist equipment that they have. On the morning of 30 April, in the hours before the IED blast, a UK Combat Logistics Patrol and an EOD Unit also travelled along the route but did not detect anything. Of course, there were no ground signs because, unusually, there was an underground tunnel stretching some 15/20 metres from a nearby compound to a point underneath the road. The IED had not been dug into the road or the side of the road as usual and, consequently, there were no ground signs to be seen.
5	**<u>CORONER'S CONCERNS</u>** During the course of the Inquest the evidence revealed matters giving rise to concerns. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to make this report to you. The **MATTERS OF CONCERN** do not solely relate to PISTOL hits but are potentially wider. They are the following: - The nature of the hits and the period over which they were received should have been more accurately and widely circulated on the relevant Intelligence database. The commanders of the Patrol were aware there had been PISTOL hits at the location (but not frequent and continuous hits over 3/4 days) and were led to believe that the location had been cleared the day before on the 29 April when the US route clearing team travelled along Route 611. - I fully appreciate of course that lessons have been learned as part of the normal process of investigation after such a tragic incident. I understand one of the lessons is in relation to the clearance of threat warnings from routes. It appears there may be a need for more detailed consideration before a threat is removed and marked as 'cleared'.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. I may extend the period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the families. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**THURSDAY 18 DECEMBER 2014** **Mr D. M Salter – HM Senior Coroner**